

ATTACHMENT 7

Sample CMS 1500 claim form for rehabilitation agency services

HEALTH INSURANCE CLAIM FORM									
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA <div style="margin-left: 10px;"> 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> </div> </div> <div style="text-align: right;"> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">PICA</div> <div style="margin-left: 5px;">1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)</div> </div> <div style="border: 1px solid black; padding: 2px; text-align: center; font-weight: bold;">1234567890</div> </div> </div> </div>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
CITY Anytown			STATE WI		CITY 			STATE 	
ZIP CODE 55555			TELEPHONE (Include Area Code) (XXX) XXX-XXXX		ZIP CODE 			TELEPHONE (INCLUDE AREA CODE) 	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
a. OTHER INSURED'S POLICY OR GROUP NUMBER 					11. INSURED'S POLICY GROUP OR FECA NUMBER M-7				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
c. EMPLOYER'S NAME OR SCHOOL NAME 					b. EMPLOYER'S NAME OR SCHOOL NAME 				
d. INSURANCE PLAN NAME OR PROGRAM NAME 					c. INSURANCE PLAN NAME OR PROGRAM NAME 				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____				
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 					17a. I.D. NUMBER OF REFERRING PHYSICIAN 				
19. RESERVED FOR LOCAL USE 					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 436 2. 437.0 3. _____ 4. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
23. PRIOR AUTHORIZATION NUMBER 1234567					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 				
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 1234JED				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ XXX XX				
29. AMOUNT PAID \$ XX XX					30. BALANCE DUE \$ XX XX				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J.M. Authorized MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Rehabilitation Agency 1 W. Williams Anytown, WI 55555				
SIGNED _____ DATE _____					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Rehabilitation Agency 1 W. Williams Anytown, WI 55555 87654321				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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